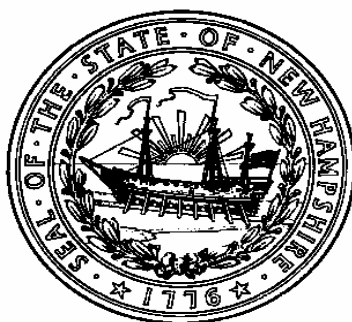


THE STATE OF NEW HAMPSHIRE



CHILD FATALITY REVIEW COMMITTEE

SEVENTH ANNUAL REPORT

*Presented to
The Honorable Craig R. Benson
Governor, State of New Hampshire
October 2004*

Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-0101NHCJA1) which is administered by the New Hampshire Department of Justice.

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DEDICATION

As in previous years, we would like to dedicate this, our Seventh Annual Report, to the children of New Hampshire and to those who work to improve their health and lives. For the last seven years that the Committee has been performing child death reviews, we have been sustained in the knowledge that what we do will improve the safety of New Hampshire's children and help to reduce the number of preventable deaths of children in the state.

LETTER FROM THE NATIONAL CENTER



August 2004

Dear State of New Hampshire Child Fatality Review Team Members:

Congratulations on the publication of your seventh annual report on child fatalities. The findings from the review process can be a powerful tool for changes in laws, policy and practices that impact the lives of the children in New Hampshire. We applaud your commitment to the child fatality review process and offer our resources and support for future efforts.

The child death review process has evolved over the years, such that today, most states have programs that review all preventable deaths. The National MCH Center for Child Death Review was established to promote, support and enhance child death review methodology and activities at the national, state and local levels. Funded by the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, the Center works to build the capacity of states to conduct effective reviews and translate findings into action to prevent deaths.

Since the National Center began, we have, collaborated with state programs, including New Hampshire, to develop support resources, protocols, standardized reporting tools, and training curricula. We greatly appreciate your help in authoring key chapters in the National Child Death review Protocol Manual and in providing guidance to other states in their program efforts.

We look forward to working with you to build upon your successes and ensure that the findings from your reviews make a difference and help keep kids alive. Thank you for the contributions that the New Hampshire Child Fatality Review Team has made to the process of child fatality review at the national level. Your expertise and willingness to collaborate with the National Center have been invaluable.

Sincerely,

Theresa M. Covington, MPH
Project Director
National MCH Center for Child Death Review

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NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

October 2004

Dear Friends of New Hampshire's Children;

The following is the Committee's Seventh Annual Report. This report reviews the work of the Committee for the calendar year 2003 and presents fatality data for the calendar year 2002. We hope that this data, and the recommendations that our reviews have generated, will challenge the public, legislative and professional communities to take action in preventing future deaths.

Members of the Committee have made both formal and informal presentations of our work to outside agencies, at national conferences, and to our colleagues who work with children. Additionally we meet annually with the teams from Vermont and Maine to share ideas and to explore ways that we can better cooperate to protect children in Northern New England. We feel that this education component is very important in publicizing our work and in also helping to strengthen the network of individuals who can have a significant impact on the prevention of child fatalities.

We have been recognized nationally as having an active and productive team that has procedures and policies that other teams around the country have emulated to become more effective in their work. A letter of support from Terri Covington from the National Center for Child Death Review has been included in this report in recognition of all the hard work we do.

Additionally, as Chair, I would like to acknowledge the hard work and dedication of the members of the Committee. Through their commitment, we have been able to build a collaborative network to foster teamwork and share the recommendations with the larger community.

In recognition of this commitment and dedication, it is with great pride that as Chair, I present the Seventh Annual Report to the Honorable Craig R. Benson, Governor of the State of New Hampshire.

On behalf of the Committee,

A handwritten signature in blue ink that reads "Marc Clement".

Marc A. Clement, Ph.D.
Chair, New Hampshire Child Fatality Review Committee

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

To reduce preventable child fatalities through systematic multidisciplinary review of child fatalities in New Hampshire; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy.

OBJECTIVES

1. To describe trends and patterns of child death in New Hampshire.
2. To identify and investigate the prevalence of risks and potential risk factors in the population of deceased children.
3. To evaluate the service and system responses to children who are considered high risk, and to offer recommendations for improvement in those responses.
4. To characterize high-risk groups in terms that are compatible with the development of public policy.
5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of the cause of death on death certificates.
6. To enable parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

Chair: Marc Clement, PhD
Colby-Sawyer College

Thomas Andrew, MD, Chief Medical Examiner
Office of the Chief Medical Examiner

Paul Boisseau, Executive Secretary
NH Board of Pharmacy

*George Bowesoxm
NH Board of Pharmacy

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Dartmouth Hitchcock Medical Center

*Lisa Bujno, MSN, ARNP, Prenatal & Adolescent Program
Chief, Bureau of Maternal & Child Health
NH Department of Health & Human Services

Edward DeForrest, PhD, Former President/CEO
Spaulding Youth Center Foundation

J. William Degnan, State Fire Marshall
NH State Fire Marshall's Office
NH Department of Safety

*Diana Dorsey, MD, Pediatric Consultant
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*Jennie Duval, Deputy Chief Medical Examiner
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NH State Police
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*Linda Griebisch, Public Policy Director
NH Coalition Against Domestic & Sexual Violence

Janet Houston, Project Coordinator
NH EMS for Children
Dartmouth Medical School

Honorable David Huot
Laconia District Court

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and NH SIDS Program Coordinator
Bureau of Maternal & Child Health
NH Department of Health & Human Services

*Melissa Mandnell, Assistant Administrator
Children's Mental Health Services
Division of Behavioral Health Services
NH Department of Health & Human Services

Honorable Willard Martin
NH Family Court Division

Sandra Matheson, Director
Office of Victim Witness Assistance
NH Attorney General's Office

Grace Mattern, Executive Director
NH Coalition Against Domestic & Sexual Violence

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CASA of New Hampshire

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Community Health Nurse

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Div. of Alcohol & Drug Abuse Prevention & Recovery
NH Department of Health & Human Services

Marcia Sink, Executive Director
CASA of New Hampshire
Paul Spivack, MD
Hitchcock Clinic

Robert Stafford, Chief
Hillsboro Police Department

Jeffery Strelzin, Senior Attorney General
NH Department of Justice

Steve Varnum, Public Policy Director
Children's Alliance of New Hampshire

*=Alternate

I. EXECUTIVE SUMMARY

This report reflects the work of the Committee during the 2003 calendar year. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce preventable child fatalities in New Hampshire.

Last year's Sixth Annual Report summarized the work of the 2002 calendar year and provided detailed data summaries for the years of 1999 through 2001. From this point forward, each report will update the three-year data summary.

This report begins with the Committee's Mission Statement and Objectives followed by a listing of the members of the Committee and their affiliations. After the Statement of Accountability, there is section entitled Agency Vignettes, followed by a review and analysis of the 2002 New Hampshire child fatality review data. The recommendations and findings from the 2003 reviews are presented along with the responses to the 2002 findings and recommendations.

II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. In 1995, then Governor Merrill signed an Executive Order (Appendix B) reestablishing the Committee under the official auspices of the New Hampshire Department of Justice. To provide support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix C) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix D) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the United States Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix E).

The Committee membership (Page ix) represents the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. The full Committee meets every other month to review the cases that have been selected by the Executive Committee. The case review protocol is Appendix F. The Committee also hosts an annual joint meeting with the teams from Maine and Vermont to share ideas and look at ways that information can be more effectively shared by different state agencies.

This is the Seventh Annual Report of the Committee, and as in previous reports, the main components of the report are the Data section and the section on recommendations that are generated during the case reviews. At the end of each year, the appropriate agencies are asked to respond to the recommendations generated by the Committee in the previous year. These responses are published along with the present year's recommendations.

The Child Fatality Review Committee is scheduled to meet six times annually to consider cases selected for review and to develop, as appropriate, recommendations to the Governor and relevant state agencies with the intent of effecting change in state policy or practice, or to cause the development of new initiatives which could lead to the reduction of preventable deaths in children and youth.

During the operating year of 2003 the Committee met to review seven cases that included death by accidental asphyxiation, acute methadone intoxication, suicide and driving related deaths. The process by which cases are reviewed is outlined in Appendix F: Case Review Protocol. The right to confidentiality for families who lost children is respected in the work of the Committee.

Committee recommendations for change are developed with the goal of creating a meaningful impact for children and youth at risk due to common factors present across the category of children represented in reviewed cases.

III. AGENCY VIGNETTES

The Committee is comprised of professionals from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. For this report two of the representing agencies were asked to describe their agency's participation on the Committee. The agencies selected are the New Hampshire Department of Education and the Office of the Chief Medical Examiner.

A. *NEW HAMPSHIRE DEPARTMENT OF EDUCATION*

The New Hampshire State Department of Education (DOE) is a long-standing member of the New Hampshire Child Fatality Review Committee. Clearly, when a school-aged child dies, it is essential to consider the child's interaction with the education system. Factors related to schooling that are both predictive of as well as protective against fatalities must be thoughtfully considered to create an educational system that considers these factors and intervenes appropriately.

Recommendations formulated in past years have addressed school health services directly as well as suggested whole school interventions. Some recommendations have targeted various specialties like driver's education, health education and family and consumer sciences and guidance departments. The New Hampshire DOE administers the Youth Risk Behavior Survey and then plans prevention curriculum that addresses current risk behaviors. Child fatalities in our state have an impact on the choice of questions considered for this survey. The Child Fatality Committee also often refers to these survey results when reviewing deaths to gain a better understanding of behaviors that might lead to such fatalities.

Having a representative from the DOE on this team ensures that appropriate personnel from the Department become engaged in implementing the recommendations. In some cases, feedback on drafts of recommendations is sought out as appropriate. The current DOE representative has been a member of the Child Fatality Committee for six years. Previous to that, she held a DHHS position for two years and participated in that capacity on the team. This consistency in membership has steam-lined the process in place to carry out team functions.

B. OFFICE OF THE CHIEF MEDICAL EXAMINER

The public role of the medical examiner varies a great deal by jurisdiction. At a minimum, the medical examiner should provide an opinion as to cause and manner of death in all sudden, unexpected or violent deaths that occur in his or her jurisdiction. The overall effectiveness of the medical examiner is dictated in large part by his or her relationship with other agencies involved in looking at these deaths including law-enforcement, prosecutors, the defense bar, Child Protective Services, schools, healthcare providers and others.

From the foregoing, one may easily see the benefits of a strong medical examiner presence in a multidisciplinary effort such as child fatality review. Benefits to the review team of the medical examiner's participation include having the death investigation process explained, interpretation of medical findings in a forensic context and the elucidation of medical information of importance beyond the immediate cause of death.

By the same token, there are substantial benefits to the medical examiner by virtue of his or her involvement in fatality review. In discussing these cases with a broad coalition of professionals, the medical examiner gains a sense of the "larger picture" of circumstances surrounding an individual's death, thus enhancing interpretive skills for future cases. Involvement in this process also embodies the medical examiner's public health mission. Information that is brought to the review table is information that would have otherwise been buried in a case report file, never to be used to educate others or even prevent future deaths of the same type. It is clear and the benefits are bidirectional, and the medical examiner's office greatly values its participation in the New Hampshire Child Fatality Review Committee.

IV. REVIEW AND ANALYSIS OF DATA

A. CHILD FATALITIES IN NEW HAMPSHIRE - 2002

This report contains information on deaths of New Hampshire residents, ages 0-18. In the year 2002, there were 104 child deaths, of that number three deaths are undetermined as to whether natural or injury and therefore are not included for purposes of analysis in this report. Of the remaining this number 70% were due to natural causes and 30% were due to injuries. Of the injury deaths, 71% were unintentional injuries (i.e. motor vehicle traffic crashes, drownings, fires, etc.) and 29% were deaths by suicide.

The analysis in this report is based on vital statistics death data from the New Hampshire Bureau of Vital Records of the Secretary of State's Office. At the time of this report, the most recent data available for analysis and reporting is 2002. More recent data is not yet available due to normal delays in obtaining out-of-state death data.

The Bureau of Health Statistics and Data Management (BHSDM) of the Office of Community and Public Health, Department of Health and Human Services completed the data analysis for this report. BHSDM's mission is to acquire and maintain complete and accurate health data for analysis and dissemination to New Hampshire communities.

This report presents deaths among children who are residents of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of deaths are analyzed in this report. For a list of the codes used for classifications of these deaths, please see Appendix G.

During 2002, 70% of all child deaths were due to natural causes. Infants (<1 year) represented 77% of all natural deaths among children through age 18 (See Table 1). Adolescents account for the majority of injury-related deaths, with deaths from unintentional injuries more frequent than those from intentional (i.e. homicide and suicide) injuries.

Table 1
New Hampshire Resident Natural and Injury Deaths**
by Age Groups 0-18, 2002

Age Group	Natural	Injury	Total
<1	54	4	58 (57%)
1 - 4	5	1	6 (6%)
5 - 9	6	3	9 (9%)
10 - 14	1	6	7 (7%)
15 - 18	4	17	21 (20%)
Total	70 (70%)	31 (30%)	101

Table Note:

****3 Deaths** undetermined whether natural or injury and are not included in this analysis.

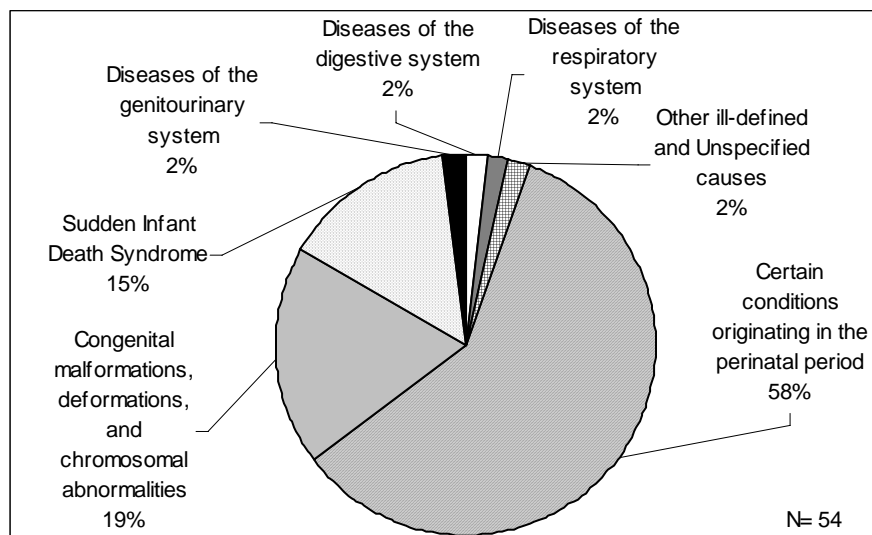
****Includes ONLY in-state deaths**

Infants are more likely to die from natural causes than older children. The major cause of death for infants is “Certain Conditions Originating in the Perinatal Period” which makes up 59% of all natural infant deaths. “Congenital Anomalies” and “Sudden Infant Death Syndrome (SIDS)” are the next two leading causes of natural death for infants (See Table 2 and Figure 1).

Table 2
New Hampshire Resident Deaths
by Natural Causes, < 1 year of age, 2002

Natural Cause of Death	< 1 yr
Certain conditions originating in the perinatal period	32
Congenital malformations, deformations, and chromosomal abnormalities	10
Sudden Infant Death Syndrome	8
Diseases of the genitourinary system	1
Diseases of the digestive system	1
Diseases of the respiratory system	1
Other ill-defined and Unspecified causes	1
Total	54

Figure 1

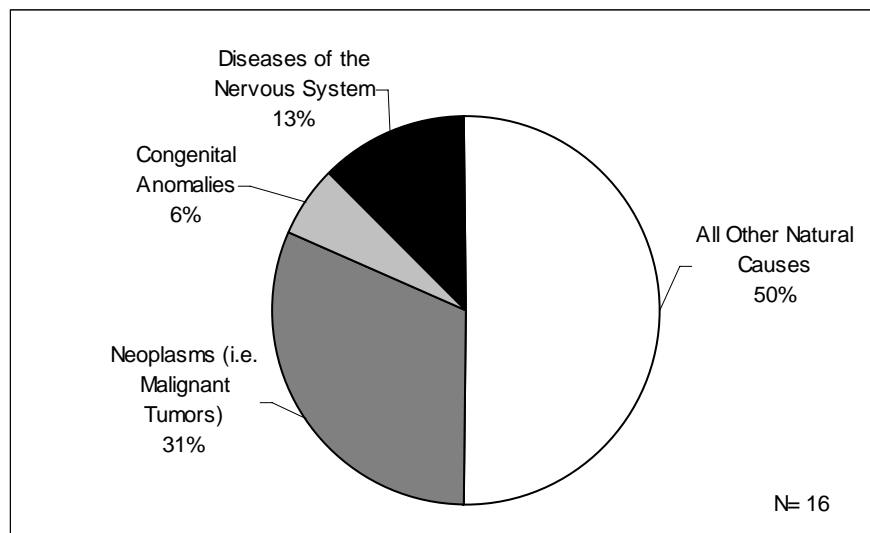


Neoplasms (malignant tumors) are the leading cause of natural death for children ages 1-18, responsible for 31% of the natural deaths. Most of the other natural causes of death for this age group are spread out among many different causes and thus the “All Other Natural Causes” category is the largest (Table 3 and Figure 2).

Table 3
New Hampshire Resident Deaths
by Natural Causes, ages 1-18 years, 2002

Natural Cause of Death	1-18 yrs
All Other Natural Causes	8
Neoplasms (i.e. Malignant Tumors)	5
Congenital Anomalies	1
Diseases of the Nervous System	2
Total	16

Figure 2



The majority of the deaths of older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. The use of age-appropriate restraints, such as infant and booster seats, reduces the risk of serious injury or death from crashes. Beginning January 1, 2004, New Hampshire state law requires that all children up to age 18 be restrained in some way and that they be in approved child safety seats if they are less than 6 years old and less than 55 inches (RSA 265:107-a).

In New Hampshire, suicides account for a number of adolescent deaths. The mechanisms of suicide deaths are firearms, suffocation (hanging), and poisoning (See Table 4).

Table 4
New Hampshire Resident Deaths
by Cause of Death, by Age Group, 2002

Cause of Death	Age in Years					Total
	< 1	1 - 4	5 - 9	10 - 14	15 - 18	
Unintentional Injuries						
Motor vehicle traffic	0	1	2	1	6	10
Suffocation	3	0	0	0	0	3
Poisoning	0	0	0	1	3	4
Fire/hot object or substance- fire/flame	0	0	1	0	0	1
Other land transport	0	0	0	1	2	3
Other	1	0	0	0	0	1
Total - Unintentional Injuries	4	1	3	3	11	22 (71%)
Suicide						
Firearm	-	-	-	1	1	2
Suffocation	-	-	-	2	4	6
Poisoning	-	-	-	-	1	1
Total - Suicide	-	-	-	3	6	9 (29%)
Total - All Intents, All Injuries	4	1	3	6	17	31 (100%)

Looking at Table 5, male children are more likely than female children to die from injury. In 2002, more than four times as many males died from unintentional injury than females and many more males completed suicides than females.

Table 5

**New Hampshire Resident Injury Deaths
by Intent, Gender and Age Group, Ages 0-18, 2002**

Unintentional Injury Deaths			
Age Group	Male	Female	Total
< 1	2	2	4
1 - 14	5	2	7
15 - 18	11	0	11
Total	18	4	22

Suicide			
Age Group	Male	Female	Total
1 - 14	3	0	3
15 - 18	5	1	6
Total	8	1	9

All Injury Deaths (All Intents)			
Age Group	Male	Female	Total
Total	26 (84%)	5 (16%)	31

Table 6 gives specific information on the causes of death for infants (less than age 1). “Certain conditions originating in the perinatal period” are responsible for 54% of all infant deaths. “Congenital malformations, deformations and chromosomal abnormalities” are the second leading cause of infant death responsible for 17% of infant deaths.

Table 6
New Hampshire Resident Deaths
by Cause of Death for Infants Less Than Age 1, 2002

Cause of Death	Count
Diseases of the Genitourinary System	1
Diseases of the Respiratory System	1
Diseases of the Digestive System	1
Certain Conditions Originating in the Perinatal Period (Total = 29)	
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	5
Disorders related to length of gestation and fetal malnutrition	11
Other respiratory conditions originating in the perinatal period	1
Intrauterine hypoxia and birth asphyxia	3
Respiratory distress of newborn	5
Hemorrhagic and hematological disorders of newborn	1
Birth Trauma	1
Other perinatal conditions	2
Congenital malformations, deformations, and chromosomal abnormalities (Total = 9)	
Congenital malformations and deformations	8
Chromosomal abnormalities	1
Sudden Infant Death Syndrome (SIDS)	8
Unintentional Injury	4
Undetermined	1
Total	54

V. 2003 FINDINGS AND RECOMMENDATIONS

- Encourage and support community based systems of care that allow for regular meetings to identify high-risk children and families.
- Implement a notification system to key stakeholders (mental health centers, schools, county attorneys, police etc.) when there is a youth suicide.
- Develop and adopt a statewide suicide prevention plan.
- The Office of Chief Medical Examiner should pursue conducting psychological profiles for all youth suicides.
- Encourage the development and compliance with the Protocols as developed by the Frameworks Suicide Project.
- Encourage mental health support and services for children who have lost a parent suddenly.
- Medical facilities or practices seeing families and children with complex disabilities such as autism, serious and profound retardism or clients with a dual diagnosis (i.e. psychosis), should have case managers or family consultants who have specialized knowledge in working with the population or someone who has in-depth awareness of child and family patterns and their needs as related to the disability.
- Medical facilities with multiple locations should have protocols to ensure patients know which site, entrance, etc. they are expected to go to - especially in urgent care situations. Optimally these protocols would require that the caller in acute situations have a chance to repeat back specific directions regarding where the visit will be held.
- Medical and/or legal investigators looking into child deaths should contact the child's primary care physician, especially if there are known medical issues/conditions relative to the child.
- Medical and pharmaceutical personnel should explain to patients and their parents the importance of prescriptions and of monitoring them.
- For youth with chronic health problems, physicians, as part of routine patient care, should work to transition them from parents managing their illness to self-management.
- Encourage the use of pharmaceutical software programs that communicate patient prescription information at 6th grade level language and terms.
- Encourage the New Hampshire Board of Pharmacy to seek more effective ways to monitor prescribing practices across, among and between pharmacies.
- Support hospice groups to establish sudden death response teams.

- Make sure all postpartum visits include assessing whether there are adequate sleeping arrangements for the baby.
- More effectively market the message of safe sleeping arrangements to teen mothers through different avenues, including peer mentor/education from other teen mothers.
- Have the Child Fatality Review Committee adopt a succinct message that would relay the benefits and dangers of co-sleeping.
- Encourage and support the development of co-located mental health and substance abuse services in schools.
- Implement student assistance program models to include middle schools.
- Develop educational materials to be distributed when medications are prescribed and dispensed on the dangers of prescription misuse.
- Provide educational materials to the New Hampshire Medical Society, pharmaceutical companies and the New Hampshire Nurses Association about the use and misuse of heroin and other opiates.
- Ensure regular updates to the Police Standards and Training Council and law enforcement on current trends in drug use/abuse.

VI. RESPONSES TO 2002 RECOMMENDATIONS

The Sixth Annual Report to the Governor, published in October 2003, listed recommendations generated from specific case reviews conducted in 2002. As with the previous reports, the appropriate agencies and/or disciplines were given a chance to address the recommendations and have provided the following responses.

A. *PUBLIC HEALTH AND HEALTHCARE*

- ***Encourage health and social service providers who conduct health screenings on newly arrived refugees and immigrants to include questions on possible heavy metal exposure (i.e. lead) and pica.***

New Hampshire adheres to the Federal Office of Refugees' "Medical Screening Protocol For Newly Arriving Refugees". Although questions on possible heavy metal exposure and pica are not specifically included in the protocol, the guidelines state that they are not all inclusive and meant to contain the principal elements for the medical screening. National journals for pediatric health care providers have included articles on what is best practice in caring for children of refugee and immigrant families in recent years. Since the lead poisoning death, the case has been presented at Dartmouth Hitchcock Medical Center's Grand Rounds, meetings with the Health Departments, the New Hampshire Pediatric Society, and the Child Health Coordinators of the state-funded child health and primary care clinics for educational purposes.

- ***Encourage primary care providers to screen for lead poisoning***

The New Hampshire Department of Health and Human Services' Childhood Lead Poisoning Prevention Program (CLPPP) encourages health care providers to test for lead at 12 and 24 months for children at highest exposure to lead which includes children enrolled in Medicaid, children enrolled in WIC, children enrolled in Head Start, children enrolled in state-funded child health and primary care clinics, children living in housing built prior to 1950, and children living in housing built prior to 1978 with renovations within the last six months. The CLPPP has written articles encouraging lead screening that have appeared in newsletters of the New Hampshire Pediatric Society, the New Hampshire Immunization Program, and the Medicaid Program mailings sent to providers. Staff from the CLPPP have done numerous educational presentations to pediatricians, nurses, health departments, state-funded health clinic staff and other health care providers on the importance of screening.

- ***Encourage the New Hampshire Department of Health and Human Services to recommend that newly arrived refugees and immigrants have an initial health screening within 30 days of arrival in New Hampshire.***

New Hampshire adheres to the Federal Office of Refugees' "Medical Screening Protocol For Newly Arriving Refugees" that recommends, ideally, that a health screening (physical exam and other health screening tests and immunizations) be conducted within 30 days of arrival in the United States, with a qualified interpreter if the refugee does not speak English. The refugee resettlement agency is responsible for arranging the physical exam, with priority given if a child has a pressing medical problem or condition, deemed a "Class B" condition, diagnosed at the physical exam done prior to their United States entry. This practice is in accordance with the American Academy of Pediatrics' policy on Health Care for Children of Immigrant Families. In some communities, a public health nurse is able to do the tuberculosis screening and immunizations at a separate, earlier time than the physical exam being provided by a local health care provider due to availability. As of approximately one year ago, the public health nurses are routinely including lead screening on children ages 6 months to 16 years at the time of the tuberculosis screening. In compliance with the New Hampshire Department of Health and Human Services' Childhood Lead Poisoning Prevention Program Screening and Management Guidelines, these newly arrived children should be screened for lead when seen for their physical exam with the local health care provider, if not previously screened.

- ***Encourage the New Hampshire Childhood Lead Poisoning Prevention Program to provide information to families and landlords about lead poisoning in a cross cultural, linguistically appropriate way.***

The New Hampshire Childhood Lead Poisoning Prevention Program (CLPPP) has translated several of their educational materials into other languages available to families, health care providers, and landlords. The CLPPP works with the New Hampshire Minority Health Coalition on lead poisoning prevention, providing a Train the Trainer Program yearly at the Minority Health Coalition's staff meeting and supplying informational materials and give-aways for the families involved with the Minority Health Coalition's programs.

- ***Provide information to health professionals, parents and those who work with children on the dangers and possible death from games resulting in accidental asphyxiation.***

Articles written by a local pediatrician on this topic appeared in the newsletters of the New Hampshire Pediatric Society, the Family Practitioner's state organization, and the New Hampshire Nurse Practitioner Association. The State Chief Medical Examiner published an article in *AAP News*, a publication of the American Academy of Pediatrics, on this topic, which won him an award for special recognition by the organization for his efforts to bring the possible tragic ramifications of a potentially deadly adolescent game to the attention of the national public.

The New Hampshire Child Health Month Coalition developed a handout for its October 2002 mailing entitled "'Games' That Can Cost A Life' that was distributed to over 5,000 providers in New Hampshire including child care providers, medical providers, foster parents, District Offices, Head Start Programs, Early Supports and Services agencies, Domestic Violence Programs, WIC Programs, and state-funded home visiting programs, primary care centers, and child health programs funded by the New Hampshire Department of Health and Human Services.

B. *EMERGENCY MEDICAL SERVICES*

- ***Educate emergency care providers about the physical symptoms and laboratory findings of lead poisoning.***

There has been no specific action taken on this recommendation to date.

C. *MENTAL HEALTH*

There were no recommendations made for mental health this past year.

D. *EDUCATION SYSTEM*

- ***Provide information to health professionals, parents and those who work with children on the dangers and possible death from games resulting in accidental asphyxiation.***

In association with the New Hampshire Child Health Month Coalition, a fact sheet entitled "'Games' That Can Cost a Life' was created and broadly distributed to schools as well as many other organizations state-wide. When this issue arises, this fact sheet is redistributed as needed. There are plans to have this available on the web during the next school year along with other Child Health Month information sheets.

- ***Increase the public's awareness about the responsibility to report suspected child abuse and/or neglect.***

The protocol "Child Abuse and Neglect: Guidelines for New Hampshire School Employees: Recognizing and Reporting Suspected Child Abuse and Neglect, 2nd Edition 2002" was presented at the annual Conference on Child Abuse and Neglect in October 2002. A hard copy was made available to every superintendent in December 2002. In January 2003, 7 copies were distributed to every school in the state. Training on using

the protocol was offered at the January 2003 Principal Association Annual Meeting and we have trained in school/districts as requested

- ***Explore adding a question to the Youth Risk Behavior Survey (YRBS) on the occurrence of games resulting in possible accidental asphyxiation.***

In 2003, there was limited opportunity to add questions due to the high demand for core requirements and the need for adding questions that track specific state performance measures as well as Safe and Drug Free School measures. Questions are determined through collaboration with Department of Health and Human Services (DHHS). Given that the YRBS samples high school students, it was determined that this may not be the most appropriate survey to inquire about asphyxial behaviors unless tracking lifetime participation is the goal. To date, no other state nation-wide has introduced a question that addressed asphyxial behaviors.

E. CHILD PROTECTIVE SERVICES

- ***Provide information to health professionals, parents and those who work with children on the dangers and possible death from games resulting in accidental asphyxiation.***

The Division for Children Youth and Families (DCYF) developed a specific section in the Child Health Diary, (partially funded with Federal Child Abuse Prevention and Treatment Act funds) regarding Preventing Choking and Strangulation, (page 138) Keeping Safe, pps, 133-144). The chapter was designed to specifically address the choking dangers of toys and foods and gives parents tips on how to determine choking and strangulation hazards as well as other safety issues (car seats, poisoning, falls, scalds, burns etc.) Diaries were given to Family Resource Center's, DHHS District Office's-licensing staff, foster and adoptive parents, foster care health nurses and pediatrician offices to be distributed to all families with newborns and young children.

- ***Increase the public's awareness about the responsibility to report suspected child abuse and/or neglect.***

Using the primary message of "Keeping her (or him) safe is everyone's responsibility" DCYF developed a number of public posters and informational flyers in both English and Spanish, that highlight everyone's responsibility to report child abuse or neglect. There was a broad distribution of these flyers and they were distributed at numerous public meetings. Additionally DCYF trained participants in its speaker's bureau to provide a broader number of individuals to speak with local community groups, including local schools, law enforcement, private agencies, etc. In addition, several presentations were provided to state wide organizations.

F. DISTRICT COURT AND LAW ENFORCEMENT

- ***Enforce correction of Certificate of Occupancy Violations, i.e. in situations such as flaking paint, to require that lead testing be done.***

There has been no specific action taken on this recommendation to date.

G. *LEGISLATION*

- *Examine model legislation from other states to make affordable rental housing safer.*

There has been no specific action taken on this recommendation to date.

H. *CHILD FATALITY REVIEW COMMITTEE*

There were no recommendations made for the Child Fatality Review Committee this past year.

VII. CONCLUSION

It is the hope of the Committee that this report has highlighted the work of the New Hampshire Child Fatality Review Committee. We hope also that it will help to strengthen your resolve to work, as an individual or a member of a public or private agency, to reduce the incidence of preventable deaths of children in New Hampshire.

APPENDIX A. HISTORY, BACKGROUND AND METHODOLOGY

(As printed in the Fourth Annual Report)

In 1999, there were 143 deaths in the state of New Hampshire involving children up to the age of 18. This compares with 134 deaths in 1997 and 119 deaths in 1998. The data presented here and in the Committee's first three annual reports shows that the great majority of the child fatalities in New Hampshire are from natural causes and that relatively few children die of preventable injury. These are the children that are of concern to the Committee and it is the task of the Committee to determine whether certain actions could have been taken to prevent these tragedies.

The Committee's First Annual Report provided an overview of the history of child fatality review committees, from their founding in Los Angeles County in 1978. In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee in New Hampshire. To assist with the initial implementation of the Committee, the University of New Hampshire Family Research Laboratory was commissioned to conduct a base-line study of child deaths in New Hampshire and to provide recommendations for how the Committee should operate.

After reviewing the study findings and initiatives from other states, the Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Stephen Merrill signed a new Executive Order (Appendix A) re-establishing the Committee under the official auspices of the New Hampshire Department of Justice. The Executive Order authorizes the Committee to have access to all existing records regarding child deaths, including social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical data and other information that may be relevant to the review of a particular child death. To provide further support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix B) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix C) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the US Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix D).

The Committee membership is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and education communities. Currently, the Committee has a dual structure consisting of the full Committee, which convenes bimonthly to conduct in-depth reviews of specific cases involving

child fatalities, and the Executive Committee, which convenes on alternate months to select cases for review, collect data and provide organizational support to the Committee.

The Committee began reviewing cases of child fatalities in January of 1996. In addition to the regular meeting schedule, the Committee hosted a joint meeting in November of 1998 with Child Fatality Review Teams from Vermont, Maine and Massachusetts. This meeting provided a forum for participants to come together and learn about some of the issues that other teams encounter in their efforts to review child deaths. It also offered an opportunity for members to establish contacts with their counterparts in other states. Participants from Maine, New Hampshire and Vermont continue to meet annually to further explore areas of common interest and to examine in more detail how each state conducts case reviews.

In New Hampshire, cases to be reviewed by the full Committee may be selected by individual members or agencies. The Committee does not review cases that have criminal and/or civil matters pending. After a case is found to be appropriate for review, the Executive Committee begins to gather information and invite participants from outside the committee who have had direct involvement with the child or family prior to the child's death.

Each child death is reviewed using the following review process (see Case Review Protocol, page three):

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.
- The Committee discusses service delivery prior to the death, and the investigation process post death.
- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future.
- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

APPENDIX B: EXECUTIVE ORDER

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

an order establishing a New Hampshire
child fatality review committee

WHEREAS, as Governor I have expressed special interest in improving services to children who are victims of abuse and neglect; and

WHEREAS, the U.S. Advisory Board on Child Abuse and Neglect has recommended that efforts be made to address the issue of child fatalities; and

WHEREAS, the formation of a standing committee composed of representatives of state agencies and relevant professional fields of practice will establish a useful repository of knowledge regarding child deaths; and

WHEREAS, in order to assure that New Hampshire can provide a continuing response to child fatality cases, the New Hampshire Child Fatality Review Committee must receive access to all existing records on each questionable or unexplained child death. This would include social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family; and


WHEREAS, the comprehensive review of such child fatality cases by a New Hampshire Child Fatality Review Committee will result in the identification of preventable deaths and recommendations for intervention strategies; and

WHEREAS, the New Hampshire Child Fatality Review Committee represents an additional aspect of our effort to provide comprehensive services for children throughout the State of New Hampshire;

NOW, THEREFORE, I, Stephen Merrill, Governor of the State of New Hampshire, do hereby establish a multi-disciplinary child fatality review committee. The objectives of this committee shall be:

1. To enable all interested parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.
2. To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
3. To evaluate the service system responses to children and families who are considered to be high risk, and to offer recommendations for any improvements in those responses.
4. To identify high risk groups for further consideration by executive, legislative or judicial branch programs.
5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.
6. To describe trends and patterns of child deaths in New Hampshire.

Given under my hand and seal at the Executive Chambers in Concord, this 29th day of September in the year of our Lord, one thousand nine hundred and ninety-five.


Governor of New Hampshire

APPENDIX C: INTERAGENCY AGREEMENT

ATTORNEY GENERAL DEPARTMENT OF JUSTICE

33 CAPITOL STREET
CONCORD, NEW HAMPSHIRE 03301-6397

PETER W. HEED
ATTORNEY GENERAL



STEPHEN J. JUDGE
DEPUTY ATTORNEY GENERAL

INTERAGENCY AGREEMENT

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made between the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety.

WHEREAS, the parties hereto as vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families.

WHEREAS, under RSA 125:9 II, the Department of Health and Human Services - Division for Public Health has the statutory authority to: "Make investigations and inquiries concerning the causes of epidemics and other diseases; the sources of morbidity and mortality; and the effects of localities, employments, conditions, circumstances, and the environment on the public health."

WHEREAS, under RSA 169-C, the Department of Health and Human Services - Division for Children, Youth and Families has the responsibility to protect the well-being of children and their families.

WHEREAS, the objectives of the New Hampshire Child Fatality Review committee are agreed to be:


- 1) To describe trends and patterns of child deaths in New Hampshire.
- 2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
- 3) To evaluate the service and system responses to children and families who are considered to be high risk, and to offer recommendations for improvement in those responses.
- 4) To characterize high risk groups in terms that are compatible with the development of public policy.
- 5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

- 6) To enable the parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.


WHEREAS, all parties agree that the membership of the New Hampshire Child Fatality Review Committee needs to be comprised of the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Pediatric Society and the New Hampshire SIDS Program.

WHEREAS, the parties agree that meetings of the New Hampshire Child Fatality Review committee will be held no fewer than six (6) times per year to conduct reviews of child fatalities.

NOW, THEREFORE, it is hereby agreed that the New Hampshire Child Fatality Review Committee convenes under the official auspices of the New Hampshire Department of Justice. All members of the New Hampshire Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. The New Hampshire Child Fatality Review Committee shall not create new files with specific case identifying information. Non-identified, aggregate data will be collected by the Committee. Case identification will only be utilized in the review process in order to enlist interagency cooperation. No material may be used for reasons other than that which it was intended. It is further understood that there may be individual cases reviewed by the Committee which will require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.


Attorney General

4/28/03
Date


Commissioner, Health and Human Services

Date


Commissioner, Department of Safety

3/28/03
Date

APPENDIX D: CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE CONFIDENTIALITY AGREEMENT

The purpose of the New Hampshire Child Fatality Review Committee is to conduct a full examination of unresolved or preventable child death incidents. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the New Hampshire Child Fatality Review Committee must have access to all existing records on each child death. This includes social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of:

agree that all information secured in this review will remain confidential and not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

Print Name

Authorized Signature

Witness

Date

APPENDIX E: STATUTORY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

As a condition for receiving funds from the New Hampshire Department of Justice through the Children's Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to "evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review process. 42 U.S.C. 5106a(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

The membership is composed of "volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse or neglect." 42 U.S.C. 5106a(c)(A)(B).

The 1996 CAPTA amendments require:

The amendments continue the requirement that, to receive funding, a state must have in effect methods to preserve confidentiality of records "in order to protect the rights of the child and of the child's parents or guardians." The persons and entities to which reports and records can be released include:

- (II) Federal, State, or local government entities, or any agent of such entities, having a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect;
- (III) child abuse citizen review panels;
- (IV) child fatality review panels;
- (V) other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose. (42 USC 5106a(b)(2)(A)(v))

Confidentiality provisions prohibit the panel's disclosure "to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information" or making any other information public unless authorized by state statutes. The amendments further provide that the state shall establish civil penalties for violation of the confidentiality provisions, 42 USC 5106a(c)(4)(B).

APPENDIX F: CASE REVIEW PROTOCOL

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.
2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).
3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.
 - A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, and accident other than traffic.
 - B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.
 - C. Cases may be selected for full Committee review by the Executive Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.
 - D. The review focuses on such issues as:
 - Was the death investigation adequate?
 - Was there access to adequate services?
 - What recommendations for systems changes can be made?
 - Was the death preventable?*
4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.
5. The CFRC will develop periodic reports on child fatalities, which are consistent with state and federal confidentiality requirements.
6. The CFRC will convene at times published.
7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.
8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.
9. The CFRC Executive Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

***WHAT IS A PREVENTABLE DEATH?**

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. “Reasonable” is defined as taking into consideration the conditions, circumstances, or resources available.

APPENDIX G: LIST OF ICD-10 CODES USED FOR ANALYSIS

List of ICD-10 Codes Used for Analysis

Cause of Infant Death Group (<1 year)	ICD-10 Code
Certain infectious and parasitic diseases	A00 - B99
Malignant neoplasms	C00 - C97
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Dis. of blood and blood-forming organs and certain disorders involv. immune mech.	D50 - D89
Endocrine, nutritional, and metabolic diseases	E00 - E88
Diseases of the nervous system	G00 - G98
Diseases of the ear and mastoid process	H60 - H93
Diseases of the circulatory system	I00 - I99
Diseases of the respiratory system	J00 - J98
Diseases of the digestive system	K00 - K92
Diseases of the genitourinary system	N00 - N98
Certain Conditions Originating in the Perinatal Period	P00 - P96
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	P00 - P04
Disorders related to length of gestation and fetal malnutrition	P05 - P08
Birth trauma	P10 - P15
Intrauterine hypoxia and birth asphyxia	P20 - P21
Respiratory distress of newborn	P22
Other respiratory conditions originating in the perinatal period	P23 - P28
Infections specific to perinatal period	P35 - P39
Hemorrhagic and hematological disorders of newborn	P50 - P61
Syndrome of infant of a diabetic mother and neonatal diabetes mellitus	P70.0 - P70.2
Necrotizing enterocolitis of newborn	P77
Hydrops fetalis not due to hemolytic disease	P83.2
Other perinatal conditions	Any other in range
Congenital malformations, deformations, and chromosomal abnormalities	Q00 - Q99
Congenital malformations and deformations	Q00 - Q89
Chromosomal abnormalities	Q90 - Q99
Symptoms, signs and abnormal clin and lab findings, not elsewhere class	R00 - R99
Sudden Infant Death Syndrome (SIDS)	R95
Other symptoms, signs and abnormal clinical and laboratory findings, nec	R00 - R53 R55 - R94 R96 - R99
Unintentional Injury	V01 - X59 Y85 - Y86
Suicide	X60 - X84 Y87.0, U03
Homicide	X85 - Y09 Y87.1, U01- U02
Undetermined Intent Injury	Y10 - Y34 Y87.2, Y89.9

List of ICD-10 Codes Used for Analysis

Cause of Death Group (1-18 years)	ICD-10 Code
Certain other intestinal infections	A04, A07-A09
Meningococcal infection	A39
Septicemia	A40 - A41
Other and unspecified infectious and parasitic diseases	A00, A05, A20-A36, A42-A44, A48-A49, A54-A79, A81-A82, A85.0-A85.1, A85.8, A86-B04, B06-B09, B25-B49, B55-B99
Malignant neoplasms	C00 - C97
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Diabetes Mellitus	E10 - E14
Major cardiovascular diseases	I00 - I78
Influenza and Pneumonia	J10 - J18
Chronic lower respiratory diseases	J40 - J47
Other diseases of respiratory system	J00-J06, J30-J39, J67, J70 - J98
Infections of kidney	N10-N12, N13.6, N15.1
Certain conditions originating in the perinatal period	P00 - P96
Congenital malformations, deformations, and chromosomal abnormalities	Q00 - Q99
Symptoms, signs and abnormal clinical and laboratory findings, nec	R00 - R99
All other diseases (Residual)	Residual
Unintentional Injury	V01 - X59 Y85 - Y86
Suicide	X60 - X84 Y87.0, U03
Homicide	X85 - Y09 Y87.1, U01- U02
Undetermined Intent Injury	Y10 - Y34 Y87.2, Y89.9